Commonwealth of Virginia
Department of Social Services

Neighborhood Assistance Program
Services Contribution Data Sheet

To Be Used For Donated Medical Professional Services
(Use Additional Sheet of Paper if Necessary)

PRINT NAME OF DONOR: _____

ADDRESS: _____

TYPE OF SERVICE PROVIDED: _____

JOB TITLE	**DATE** (List each date separately)	**HOURLY RATE** (excludes fringes)	**TOTAL HOURS WORKED**	**TOTAL VALUE** (Rate x Hours)

NOTE: Other formats providing the same information will be accepted. Sign and attach this form to the CNF or other format and return to the NAP Organization.

CERTIFICATION BY MEDICAL PROFESSIONAL: I certify that the value of the donated service(s) was determined by the standards stated in the instructions and does not exceed the statutory maximum. I also certify I will not receive any type of compensation or reimbursement from medical insurance filing or from my company for the donated service(s) nor will my company receive any compensation. I understand that if I falsify information, I may be subject to penalties prescribed by the Virginia Departments of Taxation and Social Services.

_____ _____ _____

Date Signature of Donor Phone Number

Revised 7/10